Department of Veterans Affairs **VHA DIRECTIVE 2004-031**
Veterans Health Administration
Washington, DC 20420 **July 6, 2004**

GUIDANCE ON PRIMARY CARE PANEL SIZE

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes the requirement that VHA primary care practices establish maximum panel sizes for all Primary Care Providers (PCPs) and Associate Providers (APs) identified in the Primary Care Management Module (PCMM) software. ***NOTE:*** *The panel represents the maximum number of "active patients" for whom this provider should deliver primary care.*

2. BACKGROUND

a. Providing guidance on determination of panel size, with the aim of establishing a primary care system that balances productivity with quality, access, and patient service, this Directive builds on past directives that required the use of PCMM to assign patients to PCP as part of the management of VHA outpatient primary care. Primary Care Providers manage the overall care provided to a large majority of veterans in the Department of Veterans Affairs (VA) health care system and, as such, are an important factor in determining the total number of patients that can be cared for in the system. In response to the growing number of veterans wanting to use VA health care services, there is a need to quantify the primary care capacity that is available so that demand and supply can be better aligned. In addition, with the continued expansion of the patient population served by VHA, there is a need to establish a productivity and staffing model for primary care. Such a model must balance the needs of accommodating growing numbers of patients with appropriate productivity expectations, and maintaining quality and access for established patients, and enhancing customer service and staff satisfaction. In response to these needs, the Deputy Under Secretary for Health appointed an Advisory Group on VHA Physician Productivity and Staffing. The full report of the Primary Care Subcommittee of this Advisory Group, available at http://vaww1.va.gov/med/clincare/c_primary_care.cfm includes further details of the analyses referred to in following paragraphs.

b. Health systems research has demonstrated that clinic support, both in terms of capital assets (space and exam rooms) and support staff, significantly impact physician productivity. Any standard for productivity must, therefore, incorporate guidance on clinic support. It is also recognized that severity of illness and reliance on VHA (defined as the proportion of medical care an individual receives from VHA) are factors that affect demand for primary care services. Standards to allow for adjustment for these factors are important elements of a staffing model. A model that establishes productivity standards that are comparable to non-VHA benchmarks also provides assurance to stakeholders that VHA, as a publicly funded organization, is appropriately utilizing the resources provided to it.

c. VHA has recently implemented standard business rules for determining "active patients" in PCMM and for counting provider resources dedicated to primary care. This allows, for the first time, a national roll-up of PCMM data on primary care panels. This roll-up showed that, in May 2003, the mean panel size in VHA was 1,088 for 1.0 Full-time Equivalent (FTE) physicians (MD) working full-time in primary care, and 789 for 1.0 FTE non-physician provider (Nurse

Practitioners (NP) or Physician Assistant (PA)). Recently completed surveys of primary care clinics indicated that providers had an average of 2.17 clinic support staff and 3.0 rooms per 1.0 FTE provider. Detailed analysis of VHA experience demonstrated that increased support staff and clinic rooms were associated with the improved productivity of providers, supporting the findings from the private sector. Patient characteristics reflecting disease severity and reliance had substantial impact on the need for primary care visits, on the use of primary care services as measured by Medicare Relative Value Units (RVUs), and on existing panel sizes. These analyses also provided information on the magnitude of the effect that both patient characteristics and system support had on patient need for primary care services and on panel size.

d. It was also found that significant variation in the need for primary care services and in the size of current panels existed, independent of those factors that could be measured at a national level. Such factors may include the comprehensiveness of care provided by the primary care team, degree of implementation of Advanced Clinic Access approaches, education and training activities, as well as disease severity, reliance, and clinic system support factors not captured with existing tools.

e. While methodological challenges exist in developing valid comparisons between VA and non-VA health care systems, comparison to non-VA benchmarks indicate the productivity of individual VHA providers is similar to those in other systems. The Automated Staffing Assessment Model of the United States Army provides for 1.0 civilian contract MD FTE, with 2.8 support staff and 2.5 clinic rooms for each 1,178 individuals in the populations served by a given Medical Treatment Facility. The Army Medical Command serves a mix of active duty personnel, dependants and retirees that is on the whole younger and healthier than VHA patients. Similarly, information on outpatient visits by general internists in private practice, in academic faculty practices, in geriatrics, and by NPs in General Internal Medicine practices, reveals that, for the VHA population, current VHA panels are in line with the productivity expectations of non-VA organizations. Finally, analysis of private sector survey data reveals private practice physicians average more visits per hour than VHA physicians. However, when adjustments are made for differences in patient characteristics and practice characteristics, including existing level of support staff, VHA providers have similar productivity.

f. **Specialized Panels.** The guidance in this Directive applies to undifferentiated primary care populations followed in primary care clinics with Primary Care Decision Support System (DSS) stop code 323. It is recognized that some providers may serve as PCPs for specialized panels of patients with specific, complex diseases. For example, Infectious Disease specialists may serve as PCPs for panels of patients with Human Immunodeficiency Virus (HIV) infection, or Spinal Cord specialists may serve as PCPs for panels of Spinal Cord Injury (SCI) patients. The model for Primary Care Intensity Score is not designed to account for such highly-specialized panels. It is recognized that panel sizes for specialized panels may need to be smaller than for undifferentiated primary care panels. This is acceptable, and maximum panel size for these providers and panels need to be determined locally, incorporating guidance from national programs where available. ***NOTE****: If a specialist is providing primary care to an undifferentiated general primary care population, there should be no adjustment for expected*

panel size simply because of additional specialty training. Such providers should follow the usual primary care panel.

g. **Precepting PCPs**

(1) Associate providers are individuals providing primary care under the supervision of a precepting PCP. All residents are APs, while NPs and PAs may function either as APs or, if their scope of practice or locally established privileges encompasses the skills and responsibilities required to provide primary care for the patient, as PCPs. APs may have their own defined panel, with patients assigned specifically to them. Alternatively, a PCP and AP team may practice without assigning patients specifically to the AP, but rather assigning all patients directly to the precepting PCP.

(2) When patients are assigned directly to an AP, the maximum panel size entered into PCMM (field 404.57, .08) for that AP should represent the maximum number of patients for which an AP can provide care. The number entered into this field for the precepting PCP should represent only the number of non-precepted patients for which the PCP can provide care. Total panel size for the precepting PCP is measured by adding the non-precepted panel size and the panel sizes of the APs precepted by the PCP. This is consistent with current PCMM practice that measures total active patients for precepting PCPs as the sum of non-precepted patients (assigned only to that PCP) and precepted patients (assigned to APs under the supervision of that PCP).

(3) When the precepting PCP and AP team practice without assigning any patients specifically to the AP, the maximum panel size for the AP should be entered as zero. The maximum panel size entered for the PCP should represent the number of patients for which the combined team can provide care.

h. Additional clinic rooms will be needed when residents, students, and trainees from other disciplines are participating in clinical activities in primary care. In some cases, such as in larger resident clinics, additional support staff will be needed, as well. The educational mission of VHA is critical, and provision of the appropriate clinic environment is a necessity for this mission. It is worth noting that, within VHA as a whole, the presence of resident clinics is associated with larger panel sizes for their attending physicians, since residents' patients are counted in their attending panels per the directive on PCMM. However, due to the great variation in the nature and scope of training programs, general guidance on adjustments for these activities is not provided. Whether and how much a site should adjust panel size when staff is supervising residents should be determined locally.

i. **Best Practices.** Many factors that affect panel size are not fully understood at the current time. VHA strives to be a learning organization, committed to continuous improvement. A given site may have panel sizes that exceed expectations derived from this guidance. Provided excellent performance in the areas of quality, access, patient service, and staff satisfaction is demonstrated, such variation may represent best practices and is fully acceptable under this Directive.

3. POLICY: It is VHA policy that a maximum panel size must be identified for each PCP and AP and must entered into PCMM.

4. ACTION

a. **Facility Director.** The facility Director is responsible for ensuring that the Service or Section Chief with responsibility for the Primary Care Program at a given site, in consultation with the Chief of Staff, has the responsibility for ensuring that expected panel sizes are determined for each PCP and AP. Entry of maximum panel sizes for each PCP must be accomplished no later than September 30, 2004. Thereafter, the information should be kept up to date on an ongoing basis as changes in the clinics occur.

(1) **Maximum Panel Size.** For each PCP and AP in PCMM, a maximum panel size will be identified. This represents the maximum number of "active patients" for whom this provider should deliver primary care. This should be entered in the PCMM field "Patients per Position: Allowed" on the "Settings" tab of the "Primary Care Position Setup" window in the PCMM Graphical User Interface (GUI) software. The data is saved to the "Team Position" (file # 404.57) and "Max Number of Patients" (field .08). For the remainder of this Directive, the term "panel size" is used to refer to maximum panel size and represents the primary care capacity of that provider.

(2) **Entry of Panel Size.** The precise number of each provider's maximum panel size is to be determined and entered into PCMM locally. This is to allow adjustment for the wide variety of factors that can affect the number of patients for whom a given provider can deliver quality care. ***NOTE:*** *These determinations should incorporate the guidance in this Directive.*

(3) **Panel Size.** Expected panel sizes will vary from site to site depending upon patient characteristics of the primary care population and level of system support. For sites with a patient population reflecting the norms for disease severity and reliance on VHA, and who have current norms of 2.17 support staff per 1.0 FTE provider and 3.0 clinic rooms per 1.0 FTE provider, an expected panel would be 1,200 patients for a full-time, established primary care physician. After adjustment for the factors identified, expected panels for VHA primary care providers will largely fall in the range of 1,000 to 1,400.

(4) **Adjustments in Panel Size.** Adjustments to panel size should be made utilizing the factors identified. Adjustments should be made independently and are additive. Adjustments for support staff, rooms, and patient characteristics are made at the level of the individual site. A site is a distinct service site, such as a Community-based Outpatient Clinic (CBOC) or VA medical center, with its own station number in the national institution file (Institution file #4, Station Number field #99) as opposed to its administrative parent institution, which generally incorporates several service sites. It is not expected that each individual panel at a given site be adjusted, although sites may use this information to adjust individual provider expectations, if desired. However, the average panel size for a given site should be based on the average expected panel size for that site.

(a) Support staff ratio is defined as the number (FTE) of staff present in the clinic area assisting providers with delivery of primary care per 1.0 FTE provider. It consists of Registered Nurses (RNs), Licensed Practical Nurses (LPNs), pharmacists, medical assistants, health technicians, as well as medical clerks in the clinic. Staff involved in the Coumadin Clinic and Telephone Care for the primary care patients should be counted, even if located in a separate area. Staff dedicated to business office functions (means testing, registrations, or billing), phlebotomy, file room activities, or supporting non-primary care clinics should not be included or should be pro-rated for the amount of time spent supporting primary care. Dietitians and social workers are valuable members of the primary care team but, for purposes of obtaining comparable measurement of support staff across all sites, should not be included in this count. Additional details on methodology for counting support staff is provided in Attachment A.

1. Adjustment in panel size from the baseline of 1,200 for levels of support staff should be made as follows, based on the ranges shown:

Support Staff per Primary Care FTE	**Adjustment to Panel Size**
≥0.0 and < 1.20	- 10%
≥1.20 and < 1.40	- 7.5%
≥1.40 and < 1.60	- 5.0%
≥1.60 and < 1.80	- 2.5%
≥1.80 and < 2.20	No adjustment
≥2.20 and < 2.40	+2.5%
≥2.40 and < 2.60	+5.0%
≥2.60 and < 2.80	+7.5%
≥2.80	+10%

2. VHA and private sector data indicate that current levels of support staff in VHA are often below the level of private sector practices and are at a level that may reduce the productivity of individual providers. At least 2.5 FTE support staff and/or providers have been recommended for VHA primary care clinics. A mix of approximately 0.5 RN, 1.0 LPN or medical assistant, and 1.0 medical clerk would represent a reasonable combination of staff. Levels above 2.5 FTE per 1.0 MDs may lead to further improvements in productivity and are encouraged.

(b) Clinic rooms include fully-equipped exam rooms, as well as interview rooms reserved for clinical staff. Levels of 2.5 rooms per 1.0 FTE provider have been recommended as a minimum for VHA. Adjustment in panel size for room availability for a baseline panel of 1,200 should be made as follows:

Rooms per Primary Care FTE	**Adjustment to Panel Size**
≥0.0 and < 2.0	- 5%
≥2.0 and < 2.75	- 2.5%
≥2.75 and < 3.25	No adjustment
≥3.25 and < 3.75	+2.5%
≥3.75	+5%

(c) VHA has analyzed patient characteristics to identify factors that affect demand for primary care services. These factors included a wide-range of demographic variables including patient age, sex, priority group, insurance status, as well as diagnoses (categorized on the basis of 'Diagnostic Cost Groups (DCGs), a well-established diagnostic classification known to be correlated with health care utilization.). These factors reflect a combination of complexity of illness and reliance on VHA. Using the data in the VHA visit file for primary care clinics, a model has been developed which predicts the average number of primary care visits an identified primary care population would make given its patient characteristics. This predicted number of visits is compared to the VHA average, providing a "Primary Care Intensity Score." A score of 1.0 represents the norm for VHA. A score above 1.0 indicates a patient population that is sicker and/or more reliant on VHA than the VHA average, and a higher number of primary care visits is expected. A score below 1.0 indicates that the patient population has a lower burden of illness and/or less reliance on VHA than the VHA average. Adjustment in panel size for patient characteristics should be made as follows:

Primary Care Intensity Score	**Adjustment in Panel Size**
<0.6	+10%
≥0.6 and < 0.7	+7.5%
≥0.7 and < 0.8	+5%
≥0.8 and < 0.9	+2.5%
≥0.9 and < 1.1	No adjustment
>1.1 and < 1.2	- 2.5%
≥1.2 and < 1.3	- 5%
≥1.3 and < 1.4	- 7.5%
≥1.4	-10%

(d) Panel size should be pro-rated according to the time the provider spends in Primary Care Direct Patient Care. Business rules for determining Primary Care Direct Patient Care time are provided in Directive 2003-022.

(e) 1.0 FTE non-physician provider (NP or PA) is expected to carry a panel 75 percent the size of a 1.0 FTE MD. However, ratios of support staff and space should be the same for a 1.0 FTE non-physician provider as for a 1.0 FTE MD provider.

(f) For newly-hired providers who are building a panel of new patients, a time period of 12 to 15 months is provided to achieve a full panel the same size as an established provider. For the purposes of pro-rating capacity, maximum panel size for such providers should be set at 50 percent of a fully-established provider for the first 6 months, at 75 percent for the second 6 months, and then at 12 months increased to 100 percent.

(g) For newly-hired providers assuming responsibility for an established panel, approximately 9 months is allowed before that provider would have the capability to care for the panel of a fully established provider. For purposes of pro-rating capacity, the maximum panel size of such providers should be set at 75 percent of an established provider for these 9 months.

b. **Veterans Integrated Service Network (VISN) Support Service Center (VSSC).** VSSC has the responsibility **f**or the Revision of Adjustment Factors. The VSSC must post on its web site at http://klfmenu.med.va.gov/primarycarestaffing/ a listing of PCP FTE, Primary Care Intensity Scores, and current levels of clinic room and clinic support staff for each site. On an annual basis, VSSC, working in conjunction with the Program Director for Primary Care, will be responsible for revising the Primary Care Intensity Score Model, using data from the preceding fiscal year and providing revised Primary Care Intensity Scores for each site. Selected staff in each VISN designated by their VISN Chief Medical Officer (CMO), working in conjunction with VSSC, will have the ability to update this information on an ongoing basis. At the beginning of each fiscal year, confirmation will be required from each VISN that the information on the website has been updated on an ongoing basis and is accurate.

5. REFERENCES

a. Final Report of the VHA Ambulatory Care Infrastructure Assessment, 1999.

b. Report of the Primary Care Subcommittee of the Advisory Group on VHA Physician Productivity and Staffing, .

6. FOLLOW-UP RESPONSIBILITY: The Program Director for Primary Care (111PC) is responsible for the contents of this VHA Directive. Questions may be directed to (202)-273-8558.

7. RECISSION: None. This VHA Directive expires May 31, 2008.

S/ Arthur S. Hamerschlag for
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Acting Under Secretary for Health

Attachment

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ATTACHMENT A

METHODOLOGY FOR COUNTING SUPPORT STAFF FULL-TIME EQUIVALENT (FTE) AND CLINIC ROOM

1. DEFINITIONS

a. **Support Staff.** Support Staff is defined as staff present in the clinic area assisting providers in the actual delivery of primary care to patients. It consists of Registered Nurses (RNs), Licensed Practical Nurses (LPNs), pharmacists (including Doctorates of Pharmacology (PharmDs)) medical assistants, health technicians, as well as medical clerks in the clinic. Staff involved in the Coumadin Clinic and Telephone Care for the primary care patients should be counted, even if located in a separate area. Staff time dedicated to Business Office functions (means testing, registrations or billing), phlebotomy, file room activities, or supporting non-primary care clinics should not be included or should be prorated for the amount of time spent supporting primary care. Dietitians and social workers are valuable members of the primary care, but for the purposes of obtaining comparable measurement of support staff across all sites, should not be included in this count.

(1) Time spent in the following activities should be included in the determination of support staff of Full-time Equivalent (FTE) employees:

(a) Checking patients in and out of primary care appointments.

(b) Obtaining vital signs, collecting medical information, and completing health screening questionnaires.

(c) Clinic nursing activities, such as: patient education, nursing evaluations, injections, and other office procedures.

(d) Independent follow-up visits by nurses, registered pharmacists (RPhs) or PharmDs for management of blood pressure, diabetes, cholesterol, etc.

(e) Management of anticoagulation.

(f) Telephone calls for primary care patients.

(2) Time spent in the following activities should not be included:

(a) Phlebotomy.

(b) Business Office functions, such as enrolling new patients, means testing and billing.

(c) Support for specialty or mental health clinics.

(d) Support by dieticians, social workers, or other health care professionals not directly. working with the primary care providers.

(e) Time spent by pharmacists filling prescriptions (for example, at a satellite pharmacy at a Community-based Outpatient Clinic (CBOC)).

(3) Pro-rating support staff FTE. In cases where the support staff performs more than one function or supports non-primary care clinics as well as primary care, support staff FTE needs to be adjusted. Staff should be pro-rated for the time they spend in primary care support versus time spent in other activities.

(4) Vacant Positions. Sites may have vacant positions on their organizational charts that are not in the process of active recruitment. Such positions should not be counted, since including such vacancies will not provide an accurate measurement of the system support actually provided to primary care providers.

b. **Physical Support**

(1) **Exam Rooms.** Exam Rooms are defined as fully-equipped rooms in which providers and other staff may interview and examine patients. The total number of exam rooms in the clinic should be counted. ***NOTE:*** *The question is not whether each provider uses one or two exam rooms while working in the clinic. Instead, one is attempting to determine the total number of rooms available in the clinic. Clinic management determines how patient flow proceeds and how many rooms the provider utilizes.*

(2) **Pro-rating Rooms.** In cases where the clinic area is used for other activities in addition to primary care, the exam room count would need to be adjusted. For example, if a specialty clinic provider uses an exam room 20 hours a week and that particular exam room is available for primary care 20 hours per week, that equals 0.5 exam rooms in the exam room count.

(3) **Interview Rooms.** Interview rooms are defined as rooms in the clinic area used by clinical (not administrative) staff, but which are not fully-equipped exam rooms. The count for interview rooms follows the same rules as for exam rooms.

2. EXAMPLES

Big City VA Medical Center is a large metropolitan, academically-affiliated VA medical center. It has two CBOCs: Rural Area CBOC and Small Town CBOC. The following example illustrates how support staff and exam rooms should be counted:

a. **Rural Area CBOC**

(1) This is a VHA-staffed CBOC with two physicians dedicated full-time to clinical primary care (2.0 FTE Primary Care Direct Patient Care). In the clinic, there is also 1.0 RN, 1.0 LPN, and 1.0 medical clerk. There are no specialty clinics at the CBOC. VHA staff there are not involved in phlebotomy or Business Office functions.

(a) The support staff handles all the telephone care for their primary care population and the RN, with the supervision of the physicians, manages the Coumadin Care.

(b) Each of the physicians has one exam room. The RN has one exam room and the LPN uses an interview room that is not a fully equipped exam room. The medical clerk works in the check-in area.

(2) The counts for this clinic would be as follows:

(a) RN	1.0
(b) LPN	1.0
(c) Pharmacist	0.0
(d) Medical Assistant and/or Health Technician	0.0
(e) Medical Clerk	1.0
(f) Separate Telephone Care	0.0 FTE
(g) Separate Coumadin Care	0.0 FTE

Total Support Staff	**3.0 FTE**	**Support Staff per Provider FTE = 1.5**
(h) Exam Rooms	3.0	
(i) Interview rooms	1.0	
Total Rooms	**4.0**	**Rooms per Provider FTE = 2.0**

(3) ***KEY POINT:*** *Clinic support is based on the total number of support staff and total number of rooms available, not the number of exam rooms each provider is using during clinic or the number of staff assigned to a specific provider.*

b. **Small Town CBOC**

(1) This CBOC is staffed by two physicians and one Physician Assistant (PA), each dedicated full time to clinical primary care (3.0 Primary Care Direct Patient Care FTE). There are two RNs, four LPNs, and 3.0 medical clerks in the clinic. There is one social worker that provides social work support to primary care and sees some patients for mental health counseling. Two LPNs spend 4 hours each every morning doing phlebotomy (8 hours per day or 1 FTE). One of the medical clerks spends 4 hours a day doing Business Office functions (enrollment, means testing, etc.)

(a) The support staff handles all the telephone care for their primary care population and the RNs, with the supervision of the physicians, manage the Coumadin Care.

(b) Each provider has three exam rooms. The RNs have one exam room each. The LPNs do not have their own rooms, but prep patients in the providers' empty exam rooms. The social worker has an interview room. The medical clerks work in a check-in area.

(2) The counts for Small Town CBOC would be as follows:

(a) RN		2.0
(b) LPN		3.0 ***NOTE:*** *1.0 of the four LPN FTE is dedicated to phlebotomy.*
(c) Pharmacist		0.0
(d) Medical Assistant and/or Health Technician		0.0
(e) Medical Clerks		2.5 ***NOTE:*** *0.5 of the 2.5 clerk FTE is dedicated to Business Office function.*
Total Support Staff	**7.5**	**Support Staff per Provider FTE = 2.5**
(f) Exam rooms		11.0
(g) Interview rooms		0.0 ***NOTE:*** *Do not count room used by the social worker, as it is not available to primary care staff.*
Total Rooms	**11.0**	**Rooms per Provider FTE = 3.67**

(3) ***KEY POINTS***

(a) One should pro-rate the FTE for those staff that are spending time in non-primary care activities.

(b) One should not include Social Workers or dietitians, or the rooms they require.

c. **Big City VA Medical Center**

(1) Big City is an academically affiliated metropolitan hospital. Primary care is delivered through two teams, the "Red Stripes" team, located on the east wing and the "Blue Stars" team, located on the west wing of the medical center.

(a) Red Stripes team has ten physicians, (Drs. A, B, C, D, E, F, G, H, I, and J) each spending 0.5 time dedicated to primary care (5.0 Primary Care Direct Patient Care FTE total.) Some afternoons during their clinic time, physicians supervise residents in primary care clinic. There are 2.5 RNs and three LPNs, as well as three medical clerks.

(b) Blue Stars team has five physicians (Drs. K, L, M, N and O) dedicated full-time to clinical primary care (5.0 Primary Care Direct Patient Care FTE). It also has two RNs, two LPNs and two medical clerks.

(c) Telephone calls for both practices are handled by a telephone call center staffed by one RN and one medical clerk.

(d) A separate Coumadin Clinic is staffed by 1.0 pharmacist and provides Coumadin Care for both practices.

(e) Red Stripes clinic area has fifteen exam rooms and Blue Stars clinic area has ten exam rooms.

(f) At Big City VA Medical Center, Dr. P, Dr. Q and Dr. R are infectious disease, renal and Spinal Cord specialists, respectively. They each serve as Primary Care Providers (PCPs) for small panels of patients with specialized conditions (HIV+, dialysis and SCI, respectively), and have panels for these patients in the Primary Care Management Module (PCMM). However, they see these patients in their specialty clinics that are held in a different area and are not part of the Red Stripes or Blue Stars practices.

(2) **Red Stripes Practice**

(a) Clinic Staff

1. RN	2.5
2. LPN	3.0
3. Pharmacist	0.0
4. Medical Assistant and/or Health Technician	0.0
5. Medical Clerk	3.0

(b) Telephone Care

1. RN	0.5
2. LPN	0.0
3.Pharmacist	0.0
4. Medical Assistant and/or Health Technician	0.0
5. Medical Clerk	0.5

(c) Coumadin Care

1. RN	0.0
2. LPN	0.0
3. Pharmacist	0.5
4. Medical Assistant and/or Health Technician	0.0
5. Medical Clerk	0.0

Total Support Staff	**10.0**

(d) Physical Layout

1. Exam rooms	15.0
2. Interview rooms	0.0

Total Rooms	**15.0**

(3) **Blue Stars Practice**

(a) Clinic Staff

1. RN	2.0
2. LPN	2.0
3. Pharmacist	.0
4. Medical Assistant and/or Health Technician	0.0
5. Medical Clerk	2.0

(b) Telephone Care

1. RN	0.5
2. LPN	0.0
3. Pharmacist	0.0
4. Medical Assistant and/or Health Technician	0.0
5. Medical Clerk	0.5

(c) Coumadin Care

1. RN	0.0
2. LPN	0.0
3. Pharmacist	0.5
4. Medical Assistant and/or Health Technician	0.0
5. Medical Clerk	.0

Total Support Staff	**7.5**

(d) Physical Layout

1. Exam rooms	10.0
2. Interview rooms	0.0

Total Rooms	**10.0**

Total support staff for site = 17.5 **Support Staff per Provider FTE = 1.75**
Total rooms for site = 25 **Rooms per Provider FTE = 2.5**

(3) ***KEY POINTS***

(a) Staff providing telephone support or Coumadin Care to primary care staff and patients should be counted, even if not physically located in the Primary Care Clinic area.

(b) If telephone support or Coumadin Clinic staff provide support to more than one primary care site, their time should be divided among the sites they serve, and pro-rated by the amount of time they spend providing support to the patients from the different sites.

(c) These counts and adjustments do not apply to specialists who provide primary care to specialized subsets of patients (and thus have panels in PCMM), but practice outside the primary care clinics.

3. FREQUENTLY ASKED QUESTIONS (FAQs)

a. **How should we count staff in centralized check in or check out?**

Staff in these areas is contributing support to primary care. An estimate of the time they spend supporting primary care should be made, and that percentage of the FTE should be included in the primary care support staff. The number of appointments in primary care versus appointments in other clinics can serve as a useful guide to that percentage.

b. **We have a full time RN clinic administrator who does not work directly in the clinic seeing patients. Should this person be counted?**

No. Only staff working directly in the clinic and supporting the providers should be included. If the clinic administrator spends part of the clinic administrator's time in the clinic delivering care, working as a Primary Care RN, that portion of the clinic administrator's time can be counted.

c. **Our providers work out of only one room when in clinic, although there are additional rooms in the clinic used by support staff. Shouldn't the exam room ratio be 1.0 per 1.0 FTE provider?**

No. The total number of exam rooms in the clinic is what is being counted.

d. **What should we do when reporting contract CBOCs?**

If you have reliable information regarding staff support and rooms in contract CBOCs, that information should be reported following the same rules as for VHA-staffed clinics. However, some contracts are with non-VA medical group practices and the particulars about support staff numbers, and exam rooms are completely unknown to VA staff. As contracts generally work on a per patient (capitated) or fee-for-service basis, there is not the same need for VHA to set specific panel expectations for individual providers at contract CBOCs. However, VHA would like all patients being provided VA primary care to be entered into PCMM and assigned a provider and team. This is true for contract primary Care services, as well as services provided by VA staff. Therefore, in the case of a contract clinic, a PCMM team should be created and these patients enrolled into that team. A best estimate of the provider FTE and the number of patients that can be followed at that clinic should be made and entered into PCMM. This will also allow VHA to determine its total capacity for primary care, including care delivered at contract clinics.

e. **Some of our rooms are used by medical students. Should they still be counted?**

Yes.

f. **We have a 24 hours a day, 7 days a week nurse telephone advice line. Should we count the FTE working during off hours?**

No. This count is measuring support available to the PCPs when they are in clinic.

g. **We have approved support staff positions that are temporarily vacant. Should we change the expected panel sizes while recruitment is in process?**

No. Turnover of support staff is an expected occurrence. It is not necessary to adjust panel sizes during temporary vacancies provided active recruitment of these vacancies is underway. The principle is to accurately measure support staff in place for the providers over the long term.

h. **A primary care physician recently retired, and we have hired locums to cover her panel. Should locums be counted in the PCP FTE count?**

Yes. As with support staff, turnover of providers is an expected occurrence. It is not necessary to adjust support staff and room ratios during temporary vacancies provided active recruitment of these vacancies is underway. The principle is to accurately measure support levels over the long term.

i. **We have a Coumadin Clinic and a Telephone Call Center based at the medical center that also provides support to the primary care programs in the CBOCs. Should some of the Coumadin Clinic and Telephone Care staff be counted in the CBOC counts?**

Yes. The portion of time the staff spends in supporting the primary care patient population based at the CBOCs should be counted to the CBOCs.